From the director …

This iteration of SG Crosstalk contains two articles that contain considerable information regarding where our inspection process is aimed. Colonel Holden discusses the global nature of JCAHO standards. In truth, this is a reflection of the nature of standards: generally speaking, particular standards are instances of abstract notions of The Good versus The Bad, and are not really stand-alone criteria. Accordingly, a Joint Commission standards like IM.7.1 (*The hospital initiates and maintains a medical record for every individual assessed or treated.)* is no more than an instance of a more abstract notion, say, "Information is preserved," with attached measurements (e.g., "Every registered patient has at least one record") and methods ("'Registration' is defined; 'patient' is defined, 'record' is defined.'"). That same abstraction applies to all informational conservation and transmission, like consults, laboratory results, and so forth; there is nothing about this abstraction that is the unique province of "IM.7.1." Recognizing these inherent patterns in JCAHO's (or any other quality-improvement organization's) standards will generally assure that a program meets *anyone's* standards.

Colonel Bloom's discussion of the hearing conservation program touches upon two exceptionally important aspects of Health Services Inspections: the obligation to inform senior leaders of the state (good and bad) of our medical services, and to evaluate the ability of the same to meet their peacetime and expeditionary obligations. We are undertaking an exceptional scrutiny of common, often systemic, problems in an attempt to understand and report on why these areas are often broken, and how some organizations have managed to overcome the underlying conceptual or systemic defect. We believe that this undertaking will substantially improve the relevance and utility of medical inspections over the next inspection cycle.

Behavioral Health: JCAHO vs. HSI

Lt Col Mark Holden

The Air Force Behavioral Health (BH) Flights frequently ask which of their programs are required to meet JCAHO standards and which are inspected strictly by the HSI team. It's a good question but falls somewhat short of capturing the whole story on this issue.

AF medical treatment facilities are required to meet all applicable JCAHO standards, regardless of the particular functional area. This requirement is contained in DoD Directive 6025.13 Clinical Quality Management Program in the Military Healthcare System, July 1995, section 4.1.2 Accreditation; and in AFI 44-119 Clinical Performance Improvement, 4 Jun 01, sections 2.1 & 2.3 Accreditation Standards.

Within the BH programs, perhaps two of the clearest examples of this are Environment of Care and Credentials. To say, "JCAHO doesn't apply to [fill in the blank]" is probably best seen as a sweeping and usually incorrect statement. It would be more accurate to ask, "Which JCAHO standards apply to [fill in the blank]?"

A corollary question is that of JCAHO Type 1 findings; any of the BH areas could get one or more Type 1 findings, but it's more likely to come from the JCAHO survey of ADAPT (which the HSI currently performs) or, from assessment/treatment of BH patients; or patient rights, or continuity of care, and so on. When the HSI inspectors find violations of JCAHO standards, they share it with the JCAHO surveyors. This is one of the joint HSI-JCAHO cooperative aspects of the Odyssey initiative. Last year, one situation in BH resulted in 4 Type 1 findings! 2 from JCAHO & 2 from the HSI (as of 1 Jan 03, HSI no longer uses the Type 1 & 2 terminology, although JCAHO still does).

In practice, the BH Flt/CC at the typical AF ambulatory MTF, will be concerned with meeting JCAHO standards in mental health and ADAPT. Although the Family Advocacy Program (FAP) does not get much JCAHO attention, except in EOC & credentials perhaps, the JCAHO standards on patient rights, assessment, treatment, continuity of care, etc do apply to FAP. This might be unofficially looked at as "semi-deemed" status.

The intent here is not to sound obscure; it's to make sure that the full story is understood. There are many misunderstandings out there. It took the current AFIA BH inspectors,
Lt Cols McKinley and Holden, quite a bit of effort to learn these facts. The best way that I know of for a BH Flt/CC to learn the applicable JCAHO standards is to review the CAM*BHC*. My understanding is that the Quality office at each AF MTF is automatically sent the latest edition as part of the AF-JCAHO contract.

Please contact one of the BH inspectors via phone or E-mail to discuss this issue further (DSN 246-2605/1517).

HEARING CONSERVATION PROGRAM – REVISITED

Col James Bloom

For CY 03, Element IG.2.1.3, Hearing Conservation Program--Clinical Aspects, has continued to present difficulties. Of 12 facilities inspected thus far this year, three had deficient programs. The common theme is failure to adequately complete the full evaluation of members with standard threshold shifts (STS) within the requisite 30-day time frame.

Even though these numbers remain high, this does represent a major improvement from CY 02. During that year, approximately 30 percent (8 of 27) facilities had difficulties with this program, including four facilities with Type 1 findings. The root cause analysis done last year revealed unclear ownership, ineffective tracking systems, lack of a definitive follow-up appointment process and lack of a non-compliance (no-show) policy as major reasons for the deficiencies. During CY 03, these continue to be major contributing factors for the three units with problems.

A recent initiative at AFIA/SG is a modification of the root cause analysis program undertaken last year. This initiative involves a root cause determination for those programs found to be fully compliant and effective. The intent is to gather information regarding management practices that lead to success in this program. To date, too few facilities have been inspected to develop any commonality. However, it appears that careful management of the STS log and aggressive follow-up appointment scheduling and tracking are keys to a successful program. As this initiative matures, additional management solutions to the problem of hearing conservation program management will likely be identified. As that happens, HQ AFIA/SG will make that information available to units to use to improve their programs.